Ivermectin Topical Cream 1% (SOOLANTRA)

Criteria for Use

July 2015

VA Pharmacy Benefits Management Services, Medical Advisory Panel, and VISN Pharmacist Executives

The following recommendations are based on medical evidence, clinician input, and expert opinion. The content of the document is dynamic and will be revised as new information becomes available. The purpose of this document is to assist practitioners in clinical decision-making, to standardize and improve the quality of patient care, and to promote cost-effective drug prescribing. **THE CLINICIAN SHOULD UTILIZE THIS GUIDANCE AND INTERPRET IT IN THE CLINICAL CONTEXT OF THE INDIVIDUAL PATIENT. INDIVIDUAL CASES THAT ARE EXCEPTIONS TO THE EXCLUSION AND INCLUSION CRITERIA SHOULD BE ADJUDICATED AT THE LOCAL FACILITY ACCORDING TO THE POLICY AND PROCEDURES OF ITS P&T COMMITTEE AND PHARMACY SERVICES.**

The Product Information should be consulted for detailed prescribing information.

See the VA National PBM-MAP-VPE Monograph on this drug at www.pbm.va.gov or http://vaww.pbm.va.gov for further information.

Exclusion Criteria

None

Inclusion Criteria *The answers to ALL of the following must be fulfilled in order to meet criteria for ivermectin 1% cream*

☐ Provider is a VA dermatologist or other provider locally designated to prescribe ivermectin 1% cream

☐ Patient has documented diagnosis of papulopustular rosacea (may be mixed presentation with other rosacea subtype)

☐ Patient has an inadequate response despite appropriate trials of at least two alternative topical treatments alone and one trial of an alternative topical treatment in combination with an oral antibiotic (see **Issues for Consideration**)

Dosage and Administration

The recommended frequency of application of ivermectin 1% cream is once daily; a pea-size amount should be applied to each area of the face (forehead, chin, nose, each cheek) that is affected and spread as a thin layer, avoiding the eyes and lips.

Issues for Consideration

- *Inadequate response despite appropriate trial* is defined as inability to achieve clearing or near clearing of papules, pustules and inflammation after at least 12 weeks of continuous therapy OR intolerance of such therapy
- Topical rosacea treatments include: metronidazole (0.75 or 1%, gel or cream); sodium sulfacetamide/sulfur lotion; azelaic acid gel 15%; clindamycin (1-2%), and various retinoids
- Oral antibiotics used in rosacea include: doxycycline, minocycline, azithromycin, clarithromycin
- Avoidance of irritants and triggers (temperature extremes, sunlight, certain foods, alcohol, etc.) should be utilized in combination with medical interventions (pharmacologic and light-based therapies) to achieve optimal control of rosacea

Renewal Criteria

- Documented benefit, superior to that of previously trialed therapies, after at least 12 weeks of treatment.

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